TOWN OF WESTPORT
VOLUNTARY REGISTRY FOR PEOPLE WITH DISABILITIES
WAIVER AND GENERAL RELEASE

Name of Registrant: _____

Name of Representative, if Registrant is being enrolled by a representative or legal guardian:

_____

Relationship to Registrant: _____

I, the undersigned, expressly understand and agree with the following:

I understand that the Town of Westport has created a voluntary registry for persons with disabilities or special needs that may assist police, fire, and other personnel in the event of an emergency. My information or that of the Registrant may be included in the registry only by completing the attached form and giving it to the Department of Human Services of the Town of Westport along with this Waiver and General Release.

I am voluntarily providing this information for myself or for the Registrant. I hereby affirm that all of the information provided in the attached registry form is accurate. I understand that the Town of Westport and its agents, representatives, volunteers, and employees are not responsible for determining whether providing information is suitable or advisable for the Registrant, or me; only I will make that decision. I understand that I must update the information provided if it changes, or as requested by the Town of Westport.

If I am a representative or legal guardian of the Registrant, I hereby represent and warrant that I have full legal power and authority, whether through a valid power of attorney or otherwise, to complete and submit the attached registry form, to execute and deliver this Waiver and General Release on behalf of myself and the Registrant, and to disclose the Registrant's health information. I agree to notify the Town of Westport immediately if my power and authority to act on behalf of the Registrant is no longer in effect for any reason whatsoever.

I understand that Town of Westport police, fire, or other personnel will not supply the Registrant, or me, with preferential consideration in an emergency because I completed and provided the Town of Westport with the attached form. I understand that the Registrant remains responsible for any costs associated with hospital or other medical care including transportation. I understand that enrollment in the registry is no guarantee that transportation or support services will be provided by the Town of Westport. I understand that the Registrant remains responsible for himself or herself in the event of an emergency and that he or she should call 911 if he or she is in a life-threatening situation even if he or she is on the registry. I grant permission, whether on my own behalf or on behalf of the Registrant, to medical providers, pharmacies, transportation agencies and others involved in the Registrant's care to provide care and disclose any information necessary to respond to health needs during an emergency.

I understand that by completing the attached form I am providing health information to the Town of Westport. My signature below indicates the voluntary waiver of my right or the right of the Registrant to the confidentiality of the information given to the Town of Westport. I understand that the Town of Westport will keep the health information confidential to the extent allowed by law, and will use it only as permitted and necessary, which may include sharing with local, state and federal agencies for preparation for emergencies and for planning of emergency response.

By signing below, I, on behalf of myself, and if a representative or legal guardian, also on behalf of the Registrant, hereby knowingly and voluntarily , to the fullest extent permitted by law, release and hold harmless the Town of Westport, its agents, representatives, volunteers, and employees from any claim, liability or potential liability including but not limited to bodily injury, property damage, accidents, injuries, or death arising out of or related to the fact that I have provided the information on the attached form, and I agree to waive and hold harmless the Town of Westport, its agents, representatives, volunteers, and employees from any claim that my providing this information to the Town of Westport creates a higher or different duty toward me or the Registrant than the Town owes to anyone who has not provided this type of information.

I have read this Waiver and General Release and fully understand its terms and voluntarily accept them and, if a representative or legal guardian, also voluntarily accept them on behalf of the Registrant.

Check one:

_____ I am the Registrant.

_____ I am an authorized representative or legal guardian of the Registrant.

_____

Sign Here

Print Name:_____

Print Address:_____

_____

Print Phone Number:_____

Date:_____

WESTPORT VOLUNTARY REGISTRY FOR PEOPLE WITH DISABILITIES

The Westport Police Department, in collaboration with the Department of Human Services, is offering a voluntary registry service for people with disabilities who may require special assistance in emergency or crisis situations. The confidential registry may provide essential information that will assist police and other emergency workers to safely address the needs of residents of all abilities. This registration will not be effective without a signed Waiver and General Release, signed by the Registrant or the authorized representative or legal guardian, as the case may be.

If you are completing this application as an **authorized representative or legal guardian**, please provide YOUR name and contact information and describe your relationship with the Registrant.

Date of Application/Update: _____

This is: (check one): _____Initial Application _____Update

NAME OF PERSON FILLING OUT THIS FORM:

Name: _____
First Last

Address: _____ Phone: _____

Email Address: _____ _____

Check one:

_____ I am completing this registration for myself as the Registrant.

_____ I am completing this registration as the authorized representative or legal guardian of the Registrant.

Relationship with the Registrant: _____

REGISTRANT INFORMATION:

Name of Registrant: _____
First Last

Do you have a preferred nickname? If yes, please include here: _____

Date of Birth: _____ Gender (Female, Male, Other):_____

Home Address: _____

Primary Phone: _____ Secondary Phone: _____

Height/Weight: _____ Race: _____ Hair Color: _____ Eye Color: _____

Any identifying characteristics? _____

Marital Status: (Married, Divorced, Not Married, Widowed) _____

EMERGENCY CONTACT INFORMATION: Please share at least one emergency contact

1st Emergency Contact:

Name: _____
First Last

Address: _____ Phone: _____

Email Address: _____ _____ Relationship: _____

2nd Emergency Contact:

Name:_____
First Last

Address: _____ Phone: _____

Email Address: _____ _____ Relationship: _____

SPECIAL CIRCUMSTANCES AND SAFETY CONCERNS: Please indicate specific needs of the Registrant in this section.

Does the Registrant live alone? Yes ◯ No ◯ Do other people live in the home? Yes ◯ No ◯

If yes, please explain by providing their names, ages and relationship.

_____

_____

Does the Registrant live in a group setting? Yes ◯ No ◯

If yes, please provide the name of the group home: _____

Please list the primary and secondary care providers' names and contact info:

Primary Care Provider

Name:_____
First Last

Address: _____ Phone: _____

Email Address: _____ _____ Relationship: _____

Secondary Care Provider

Name:_____
First Last

Address: _____ Phone: _____

Email Address: _____ _____ Relationship: _____

Does the **Registrant drive**? Yes ◯ No ◯ Does **Registrant own a car**? Yes ◯ No ◯

Are there any **firearms, in the home**? Yes ◯ No ◯

If there are firearms, **are they secured**? Yes ◯ No ◯

If they are secured, **how are they secured**? _____

Does the **Registrant have access to the firearms**? Yes ◯ No ◯

Are there any **other weapons in the home**? Yes ◯ No ◯

If there are other weapons, **what are they**? _____

If there are other weapons, **are they secured**? Yes ◯ No ◯

If they are secured, **how are they secured**? _____

Does the **Registrant have access to the other weapons**? Yes ◯ No ◯

Does the Registrant have a **history of violence**? Yes ◯ No ◯

If yes, please **explain circumstances**: _____

_____

Please indicate any impairment or disability that requires special accommodations in emergencies**:**

_____

_____

Please specify any **verbal, hearing, tactile or visual impairment** that may require special accommodations in communicating with others: _____

_____

Does applicant require **ambulatory assistance**? Yes ◯ No ◯ **Insulin dependent?** Yes ◯ No ◯

Oxygen dependent or require supplemental oxygen? Yes ◯ No ◯ **If yes, please specify**

_____

Is Registrant currently on any **life supporting equipment?** Yes ◯ No ◯ **If yes, please specify**

_____

Indicate essential emergency medications (EX. Seizure, diabetic, allergy, heart or other):

_____

_____

_____

Hobbies, Interests – this will help to us to make personal connection to the Registrant.

_____

Is the Registrant currently **employed or volunteering on a regular basis?** Yes ◯ No ◯

If yes, please provide employer name and contact info.

Employer: _____ Contact: _____

Phone: _____ Email Address: _____

Frequent locations: (places of interest) _____

_____

OTHER:

Please use the space below to indicate any other information that you believe is important. You may also include additional emergency contacts or information on the Registrant's communication preferences.

_____